2016

Improving the Medical Services System's Response to Domestic Violence

Nat Stern
Florida State University College of Law

Karen Oehme

Elizabeth Donnelly

Rebecca Melvin

IMPROVING THE EMERGENCY MEDICAL SERVICES SYSTEM'S RESPONSE TO DOMESTIC VIOLENCE

Karen Oehme, Nat Stern, Elizabeth Donnelly & Rebecca Melvin[†]

CONTENTS

INTRODUCTION

The Emergency Medical Services (EMS) System in the United States, dispatched with the national 911 emergency number, has been responsible for saving countless lives and is a crucial component of the medical system. Millions of injured and ill Americans are treated by field EMS personnel such as emergency medical technicians and paramedics—often called prehospital medical care providers—each year.[1] Because of the widespread nature of domestic violence—one of the leading causes of injuries to women and a constant challenge for the medical community[2]—researchers agree that EMS providers

† Karen Oehme is the Director of the Institute for Family Violence Studies at Florida State University College of Social Work and a Distinguished University Scholar at Florida State University. Nat Stern is the John W. and Ashley E. Frost Professor of Law, Florida State University College of Law. Elizabeth Donnelly, Ph.D., is an Assistant Professor at Windsor University. Rebecca Melvin is the Trauma Education Coordinator for TraumaOne Flight Services at University of Florida Health, Jacksonville.

1. *See* Frank Sullivan et al., *An Overview of Prehospital Emergency Medical Services*, 96 R.I. J. MED. 24, 24, 27 (2013).

2. *See generally infra* Part I.

encounter victims of such violence on a regular basis and may offer a unique and valuable route for intervening with victims of domestic violence. Unfortunately, however, the EMS system has developed haphazardly at the local level and is governed at the federal level by the U.S. Department of Transportation, the agency responsible for transportation rather than health.[3] The resulting lack of coherence has caused EMS to largely pass on an opportunity to assist domestic violence victims and prevent further injury and death caused by this crime. For a system described as straddling health care, public health, and public safety,[4] the current lack of attention to domestic violence in EMS leaves all three systems lacking in capacity to provide fundamental assistance to victims.

This Article proposes that Congress create a long overdue federal strategy for the nation's emergency health care that would include an important role for EMS in recognizing, responding to, and ultimately preventing domestic violence. Congress is already considering legislation that would place EMS under the U.S. Department of Health and Human Services, which has long recognized the public health crisis of domestic violence, as the lead oversight agency.[5] Such a transfer would substantially increase the degree of consistency and accountability of the EMS system. Without this and other measures to revamp the delivery of emergency services,[6] victims of domestic violence are likely to remain underserved by EMS, leaving the cycle of violence to continue unabated for many.

Part I of this Article describes the widespread incidence of domestic violence, its crushing health consequences for victims, and responses by the medical community and government. Part II provides an account of the historical underpinnings of EMS, including an explanation of why EMS Services were placed in a federal transportation agency rather than a health agency. Part III shows how national accreditation standards and state laws fail to ensure adequate training on domestic violence for EMS personnel. Part IV argues that a federal strategy for EMS to respond to domestic violence—one that includes housing EMS in the Department of Health and Human Services and is complemented by revisions to state law—is necessary to modernize the EMS response to victims and improve public health.

3. *See generally infra* Part II.

4. INST. OF MED., EMERGENCY MEDICAL SERVICES: AT THE CROSSROADS 37 (2007), http://iom.nationalacademies.org/Reports/2006/Emergency-Medical-Services-At-the-Crossroads.aspx.

5. *See infra* notes 100-106, 151-62, and accompanying text.

6. *See infra* Part IV.

I. THE TRAGIC IMPACT OF DOMESTIC VIOLENCE ON VICTIM HEALTH

Domestic violence, also called intimate partner violence, is a pattern of coercive behavior in which a person uses a variety of tactics including physical violence and threats, emotional abuse, financial coercion, sexual abuse, and other coercive behaviors to control an intimate partner.[7] While domestic violence is both a heinous act and serious crime, it also presents a major health problem. The costs of domestic violence, both to victims' wellbeing and to society's health care system, are immense. At the same time, medical professionals can assume a greater role than they currently play in identifying and curbing this societal and medical scourge.

While domestic violence typically takes the form of physical violence by men against women, its perpetration extends to other tactics and victims as well. Thus, domestic violence broadly includes physical violence, threats of violence, intimidation, sexual coercion, isolation, and emotional abuse[8] perpetrated by a current or former date, boy/girlfriend, spouse, or cohabitating partner.[9] Both opposite-sex and same-sex couples are included in the definition.[10] In the United States, the crime is rampant. According to a national survey by the National Center for Injury Prevention and Control, five million women in the US reported experiencing rape and/or physical violence in the 12 months,[11] while more than one in three women have suffered

7. Stephanie A. Eisenstat & Lundy Bancroft, *Domestic Violence*, 341 NEW ENG. J. MED. 886, 886 (1999).

8. *See* ABA COMM'N ON DOMESTIC VIOLENCE, TOOL FOR ATTORNEYS TO SCREEN DOMESTIC VIOLENCE (2005), http://www.americanbar.org/content/dam/aba/migrated/domviol/screeningtoolcdv.authcheckdam.pdf (last visited July 16, 2015).

9. *See* NAT'L CTR. OF INJURY PREVENTION & CONTROL, CTRS. FOR DISEASE CONTROL & PREVENTION, COSTS OF INTIMATE PARTNER VIOLENCE AGAINST WOMEN IN THE UNITED STATES 8 (2003), http;//www.cdc.gov/violenceprevention/pdf/ipvbook-a.pdf [hereinafter COSTS OF INTIMATE PARTNER VIOLENCE AGAINST WOMEN IN THE UNITED STATES]; *see also* Mary Sormanti & Erica Smith, *Intimate Partner Violence Screening in the Emergency Department*, 30 INT'L Q. OF CMTY. HEALTH EDUC. 21 (2010).

10. Sormanti & Smith, *supra* note 9, at 22.

11. MICHELE C. BLACK ET AL., CTR. FOR DISEASE CONTROL & PREVENTION, NATIONAL INTIMATE PARTNER AND SEXUAL VIOLENCE SURVEY: 2010 SUMMARY REPORT 38-39 (2011), http://www.cdc.gov/violenceprevention/pdf/nisvs_report2010-a.pdf (last visited July 16, 2015) (reporting that 35.6% of women and 28.5% of men have been have been victims of rape, physical violence, or stalking by an intimate partner in their lifetime).

some form of domestic violence in her lifetime.[12] Men are also victims of domestic violence: more than one in four men have experienced rape, physical violence, and/or stalking by an intimate partner.[13] Still, the crime disproportionately affects women. Women are three times more likely than men to sustain injuries due to domestic violence,[14] six times more likely to require medical care for injuries from domestic violence,[15] and three times as likely to be stalked.[16]

The impact of domestic violence on women's health is staggering. Overall, nearly two million injuries and nearly 1,300 deaths result each year from domestic violence.[17] Researchers estimate that between 22 and 35 percent of female patients seeking care for any reason in emergency departments have health problems related to domestic violence,[18] and that one in three female trauma patients is a victim of abuse.[19] Medical complaints of victims have included obvious injuries such as broken limbs, fractures, and bruises,[20] contusions, lacerations,

12. *Id.* at 39.

13. *Id.* at 2.

14. *See id.* at 54.

15. *See id.* at 54-55; *see also* CALLIE MARIE RENNISON, U.S. DEP'T OF JUSTICE, INTIMATE PARTNER VIOLENCE 1993-2001 (2003), http://www.bjs.gov/content/pub/pdf/ipv01.pdf.

16. *See* SHANNON CATALANO ET AL., DEP'T OF JUSTICE BUREAU OF JUSTICE STATISTICS, SELECTED FINDINGS: FEMALE VICTIMS OF VIOLENCE 3-4 (2009), http://www.bjs.gov/content/pub/pdf/fvv.pdf (stating that females were killed by intimate partners at higher rate than males).

17. COSTS OF INTIMATE PARTNER VIOLENCE AGAINST WOMEN IN THE UNITED STATES, *supra* note 9, at 1.

18. Teri Randall, *Domestic Violence Intervention Calls for More Than Treating Injuries*, 264 JAMA 939, 939 (1990); *see also* M. Gerard, *Domestic Violence: How to Screen and Intervene*, 63 RN J., 52-56 (2000) (stating that approximately 35% of emergency department patients were victims of domestic violence, and 95% of those were women).

19. Susan V. McLeer & Rebecca Anwar, *A Study of Battered Women Presenting in an Emergency Department*, 79 AM. J. PUB. HEALTH 65, 66 (1989) (finding that 30% of all female trauma victims identified positive for battering, jumping to 42% for women ages 18-20).

20. *See* Ann L. Coker et al., *Physical Health Consequences of Physical and Psychological Intimate Partner Violence*, 9 ARCHIVES OF FAMILY MED. 450, 454 (2009) (stating that repeated physical assaults often can directly impact women's health through broken bones); *see also* Ole Brink et al., *Pattern of Injuries Due to Interpersonal Violence*, 29 INJ. 705, 705-709 (1998) (finding craniofacial injuries in 69% of interpersonal violence victims and noting violence as the most frequent cause of craniofacial fractures); Daniel C. Berrios & Deborah Grady, *Domestic Violence: Risk Factors and Outcomes*, 155 W. J. MED. 133, 134 (1991)

and head trauma.[21] Victims can also suffer from sprains or strains to their feet, ankles, knees, wrists, or elbows; injuries to the tendons and ligaments are commonly caused from victims trying to escape from their partners or being intentionally hurt.[22] In addition, victims have had facial injuries,[23] teeth knocked out,[24] hematomas from blunt trauma,[25] and perpetrators' hand and finger prints left from being

(finding that 70% of victims had experienced bruises due to domestic violence).

21. *See* Bach T. Le et al., *Maxillofacial Injuries Associated with Domestic Violence*, 59 J. ORAL & MAXILLO FACIAL SURGERY 1277, 1277 (2001) (stating that domestic violence victims had experienced trauma that resulted in contusions, lacerations, and head injuries); *see also* Brink et al., *supra* note 20, at 706, 708 (finding that most victims had craniofacial injuries, as well as high rates of contusions among female victims and high rates of lacerations among male victims of domestic violence); CTR. FOR DISEASE CONTROL & PREVENTION, GET THE STATS ON TRAUMATIC BRAIN INJURY IN THE UNITED STATES http://www.cdc.gov/traumaticbraininjury/pdf/BlueBook_factsheet-a.pdf (last visited July 16, 2015) (finding that traumatic brain injury is a result of falls in 35.2% of cases, being struck by an object or against a wall in 16.5%, and assault in 10%).

22. *See* Berrios & Grady, *supra* note 20 (finding musculoskeletal injuries, including bone fractures, tendon or ligament injuries, and joint dislocations in 35% of domestic violence victims); *see also* Jacquelyn C. Campbell & Linda A. Lewandowski, *Mental and Physical Health Effects of Intimate Partner Violence on Women and Children*, 20 PSYCHIATRIC CLINICS OF N. AM. 353, 355 (1997) (noting injuries from abuse include tendon or ligament injuries).

23. *See* Le et al., *supra* note 21, at 1277 (stating that most domestic violence victims studied had maxillofacial injuries); *see also* Brink et al., *supra* note 20, at 706, 708 (finding that most victims had craniofacial injuries); John P. Kenney, *Domestic Violence: A Complex Health Care Issue for Dentistry Today*, 159S FORENSIC SCI. INT'L SUPPLEMENT S121, S123 (2006) (reporting that 81% of victims presented with maxillofacial injuries and that average number of mandible fractures per patient was 1.32.).

24. *See* Brink et al., *supra* note 20, at 706, 708 (27% of domestic violence victims had dental fractures); *see also* Kenney, *supra* note 23, at S123 ("Anterior teeth are often damaged or lost due to physical abuse").

25. *See* Carole Warshaw, *Identification, Assessment, and Intervention with Victims of Domestic Violence, in* IMPROVING THE HEALTH CARE RESPONSE TO DOMESTIC VIOLENCE: A RESOURCE MANUAL FOR HEALTH CARE PROVIDERS 49-86 (1996) (giving case scenario of victim of domestic violence with hematoma; encourages performance of a thorough physical exam on victims of domestic violence, specifically looking for areas of tenderness from potential scalp hematomas or deep bruises).

held roughed up or strangled.[26]

The cost of the public health crisis of domestic violence is measured not only in the physical and emotional trauma of its victims, but also in economic costs totaling over 8.3 billion dollars.[27] Victims lose more than thirteen million days of productivity from employment each year,[28] and the treatment of their injuries costs more than $4 billion annually.[29] These massive figures reflect the societal magnitude of domestic violence and the severity of the harm it inflicts. Nationally, almost two million injuries and 1,300 deaths result from domestic violence each year.[30] Over a half million injuries need medical attention and more than 145,000 injuries require hospitalization of the victim.[31] Researchers have determined that between 22 and 35 percent of women patients in emergency room settings are there for problems related to domestic violence.[32] One-in-three female trauma patients is a victim of abuse.[33] Over 18 million mental health visits also result from domestic violence trauma.[34]

Because of the pervasive and devastating effects of domestic violence, the medical community has made it a major focus of public health efforts.[35] Most notably, the American Medical Association

26. *See* Brink et al., *supra* note 20, at 706-07 (noting that in females, injuries on the neck from domestic violence were most frequently due to strangulation); *see also* Berrios & Grady, *supra* note 20 (finding that 23% of domestic violence victims had experienced choking or strangulation and many had bruises and neck injuries); Allison Turkel, *"And Then He Choked Me": Understanding, Investigating, and Prosecuting Strangulation Cases*, 2 AM. PROSECUTORS RES. INST. 1, 1-3 (2007) (noting high frequency at which victims of domestic violence report being choked or strangled and encouraging investigators to check domestic violence victims for bruises and fingertip or thumb prints).

27. Wendy Max et al., *The Economic Toll of Intimate Partner Violence Against Women in the United States*, 19 VIOLENCE & VICTIMS 259, 259 (2004).

28. *Id.* at 267.

29. *See id.*

30. *Costs of Intimate Partner Violence Against Women in the United States*, *supra* note 9, at 1.

31. *Id.* at 19.

32. Randall, *supra* note 18, at 939.

33. *See generally Violence* (*Position Paper*), AM. ACAD. FAM. PHYSICIANS (2011), http://www.aafp.org/about/policies/all/violence.html (last visited July 16, 2015).

34. *Costs of Intimate Partner Violence Against Women in the United States*, *supra* note 9, at 19.

35. Linda L. Dahlberg & James A. Mercy, *History of Violence As a Public Health Problem*, 11 VIRTUAL MENTOR 167, 168 (2009) (describing the

(AMA) has advocated universal screening of female patients for domestic violence.[36] This proposal stems from recognition of the important role that medical professionals can play in identifying victims and linking them to community resources to end the violence.[37] A significant reason for screening by trained professionals is that some symptoms of domestic violence presented by victims to medical professionals may not be obvious. Instead, medical complaints may be expressed as a result of stress and manifest as palpitations and shortness of breath.[38] In other cases, symptoms may be related to chronic illnesses, including conditions as wide-ranging as asthma, diabetes, irritable bowel syndrome, frequent headaches, chronic pain, somatic complaints such as difficulty sleeping, and ongoing poor physical and mental health.[39] More than half a million injuries from domestic violence require medical attention each year, and over 145,000 injuries require hospitalization.[40] Adverse mental health and mental illness are also often effects of domestic violence; an estimated

first reports made by the Surgeon General and Secretary of State about violence as a public health issue and discussing the development of new branches of critical medical agencies, including the Division of Injury Epidemiology and Control within the CDC, specifically to address violence); *see also* NEW YORK CITY MAYOR'S OFFICE TO COMBAT DOMESTIC VIOLENCE, MEDICAL PROVIDERS' GUIDE TO MANAGING THE CARE OF DOMESTIC VIOLENCE PATIENTS WITHIN A CULTURAL CONTEXT 9 (2004), http://www.nyc.gov/html/ocdv/downloads/pdf/Materials_Medical_Providers_DV_Guide.pdf (stating that the World Health Organization has recognized domestic violence as a global public-health concern). *See generally* MADELEINE DE BOINVILLE, OFF. ASST. SEC'Y FOR PLAN. & EVALUATION ASPE POLICY BRIEF: SCREENING FOR DOMESTIC VIOLENCE IN HEALTH CARE SETTINGS (2013), http://aspe.hhs.gov/hsp/13/dv/pb_screeningdomestic.cfm.

36. ENCYCLOPEDIA OF DOMESTIC VIOLENCE & ABUSE 21 (Laura L. Finley ed. 2013) (stating that the AMA has been a leader in recommending routine screening of patients for domestic violence). *See* NEW YORK CITY MAYOR'S OFFICE TO COMBAT DOMESTIC VIOLENCE, *supra* note 35, at 2 (stating that medical professionals play a crucial role in identifying victims, routine screening is critical for prevention and detection of domestic violence, and domestic violence can cause increased risk of chronic illnesses).

37. *See* NEW YORK CITY MAYOR'S OFFICE TO COMBAT DOMESTIC VIOLENCE, *supra* note 35, at 2 (stating that medical professionals play a crucial role in identifying victims, that routine screening is critical for prevention and detection of domestic violence, that domestic violence can cause increased risk of chronic illnesses).

38. Warshaw, *supra* note 25, at 54, 56-57.

39. *See* BLACK ET AL., *supra* note 11, at 62-63.

40. *Costs of Intimate Partner Violence Against Women in the United States*, *supra* note 9, at 19.

18 million mental health visits result from domestic violence.[41] Victims can develop symptoms of post-traumatic stress disorder from living in abusive situations,[42] and can experience anxiety, depression, and panic attacks caused by physical, sexual, and psychological abuse inflicted by intimate partners.[43] Leaders in the medical community have recognized the widespread nature of domestic violence and its ruinous effects on women. Multiple high-profile groups such as the American Medical Association,[44] American Association of Colleges of Nursing,[45] and the American College of Emergency Physicians[46] have emphasized the prevalence of domestic violence and the role of medical professionals in addressing it. In 2011 the Institute of Medicine (IOM) recommended clinical screening and counseling for all women and adolescent girls for interpersonal and domestic violence in a culturally sensitive and supportive manner.[47] In 2013, the U.S. Preventive Services Task Force (USPTF) recommended health screening for all

41. *Id.*

42. *See* BLACK ET AL., *supra* note 11, at 10 (listing PTSD as an indicator of more severe intimate partner violence); *see also* Jacquelyn C. Campbell, *Health Consequences of Intimate Partner Violence*, 359 THE LANCET 1331, 1333 (2002) (naming depression and PTSD as most prevalent mental health effects of intimate partner violence).

43. *See* BLACK ET AL., *supra* note 11, at 10 (listing anxiety as a health consequence of intimate partner violence); *see also* Campbell, *supra* note 42, at 1334 (naming depression and anxiety as effects of intimate partner violence); *Trauma, Mental Health, and Domestic Violence*, FLA. COAL. AGAINST DOMESTIC VIOLENCE, http://www.fcadv.org/projects-programs/trauma-mental-health-domestic-violence (listing panic attacks as effect of domestic violence).

44. *See also* AM. MED. ASS'N., DIAGNOSTIC AND TREATMENT GUIDELINES ON DOMESTIC VIOLENCE 4, 11 (1992), http://www.ncdsv.org/images/AMA_Diag&TreatGuideDV_3-1992.pdf (last visited July 16, 2015) (reporting on prevalence of violence and need for physicians to screen and provide assistance to victims).

45. *See Violence As a Public Health Problem*, AM. ASS'N COLLS. NURSING (2015), http://www.aacn.nche.edu/publications/position/violence-problem (reporting on the prevalence of violence and interventions to use with victims).

46. *See Domestic Violence: The Role of EMS Personnel*, AM. COLL. EMER. PHYSICIANS, http://www.acep.org/Clinical---Practice-Management/Domestic-Violence--The-Role-of-EMS-Personnel/ (stating that emergency medical services will encounter victims of domestic violence and should have training on care for victims).

47. INST. OF MED., CLINICAL PREVENTIVE SERVICES FOR WOMEN: CLOSING THE GAPS (2011), https://www.iom.edu/~/media/Files/Report%20Files/2011/Clinical-Preventive-Services-for-Women-Closing-the-Gaps/preventiveservicesforwomenreportbrief_updated2.pdf.

women of childbearing age.[48] In addition, the Patient Protection and Affordable Care Act includes screening and brief counseling for domestic violence as part of required free preventive services for women.[49]

II. EMERGENCY MEDICAL SERVICES: THE FRAGMENTED SYSTEM FACING DOMESTIC VIOLENCE VICTIMS

Domestic violence is a leading risk factor for injury and death for women in the U.S.,[50] and researchers have noted that "EMS professionals are often the first or only medical contact that an injured victim of domestic violence may have."[51] Much of the research on emergency medical professionals' responses to domestic violence involves studies of hospital emergency room and urgent care clinic personnel—doctors and nurses[52]—instead of prehospital personnel. Yet many injured victims ultimately refuse transport to the hospital,[53] where medical professionals[54] would presumably be able to

48. *Intimate Partner Violence and Abuse of Elderly and Vulnerable Adults: Screening*, U.S. PREVENTATIVE SERVS. TASK FORCE, http://www.uspreventiveservicestaskforce.org/Page/Topic/recommendation-summary/intimate-partner-violence-and-abuse-of-elderly-and-vulnerable-adults-screening (last viewed May 20, 2015) (stating that domestic violence screening and counseling is rated B by the U.S. Preventive Services).

49. Patient Protection and Affordable Care Act, 42 U.S.C. § 300gg-13(a)(1) (2011) (requiring services rated as an A or B by the U.S. Preventive Services Task Force to be covered by the insurer without any additional cost to the patient).

50. *See generally* CNTR. FOR DISEASE CONTROL & PREVENTION, THE NATIONAL INTIMATE PARTNER AND SEXUAL VIOLENCE SURVEY (2014), http://www.cdc.gov/violenceprevention/nisvs/.

51. *EMS Response to Domestic Violence: A Curriculum and Resource Manual*, TENN. COAL. AGAINST DOMESTIC & SEXUAL VIOLENCE 7 (June 27, 2001), https://health.state.tn.us/ems/PDF/g4011361.pdf.

52. *See, e.g.,* Melanie Boursnell & Sue Prosser, *Increasing Identification of Domestic Violence in Emergency Departments: A Collaborative Contribution to Increasing the Quality of Practice of Emergency Nurses*, 25 CONT. NURSE 35 (2010) (discussing the role of nurses). *See also* Lisa Yonaka et al., *Barriers to Screening for Domestic Violence in the Emergency Department*, 38 J. CONTINUING EDUC. NURSING 37, 40 (2007) (focusing on physicians and nurses knowledge, attitudes, barriers, and screening in an emergency department setting).

53. *See* M. Elaine Husni et al., *Domestic Violence and Out-of-hospital Providers: A Potential Resource to Protect Battered Women*, 7 ACA. EMERGENCY MED. 243, 247 (2008) (stating that victims refuse transport to a hospital once the treating medic determines that the injury is not life threatening or the wound is dressed, or the bones are determined to be unbroken because the victim may be afraid of the batterer's

offer informed care in light of federal law's renewed emphasis on screening for such violence.[55]

The roots of the current EMS system lie in a concern with rising rates of traffic accidents. Even as more Americans took to the roads, emergency medical services in the 1950s provided glorified first aid; ambulance services commonly encompassed only "a mortician and a hearse."[56] As the nation built a massive system of highways and roads after World War II, large numbers of injuries and deaths resulting from vehicle accidents captured the attention of President John F. Kennedy.[57] As a presidential candidate, he declared that "[t]raffic accidents constitute one of the greatest, perhaps the greatest, of the nation's public health problems."[58] Subsequently, President Lyndon B. Johnson and the President's Commission on Highway Safety/National Academy of Sciences described in 1966 the enormous number of accidents as "the neglected disease of modern society."[59] The resulting National Highway Traffic Safety Administration (NHTSA) was

response); Robert Apsler et al., *Fear and Expectations: Differences Among Female Victims of Domestic Violence Who Come to the Attention of the Police*, 17 VIOLENCE & VICTIMS 445, 447 (2002) (noting that 25% of victims were very afraid of their abuser); MONICA MCLAUGHLIN, NAT'L LOW INCOME HOUS. COAL., HOUSING NEEDS OF VICTIMS OF DOMESTIC VIOLENCE, SEXUAL ASSAULT, DATING VIOLENCE AND STALKING (2014), http://nlihc.org/sites/default/files/2014AG-107.pdf (stating victims sometimes remain with their abusers due to difficulty accessing housing, transportation, and childcare); *see also* Michael J Cruz, *"Why Doesn't He Just Leave?" Gay Male Domestic Violence and the Reasons Victims Stay*, 11 J. MEN'S STUD. 309 (2003) (stating that victims of domestic violence cited fear as reason to stay in relationship); Adrienne E. Adams, Economic and Mental Health Effects of Job Instability For Low-Income Survivors of Intimate Partner Violence: Two Studies (2009) (unpublished PhD. Dissertation, Michigan State University), http://gradworks.umi.com/33/63/3363790.html (stating that IPV reduces women's capacity to sustain employment, cutting them off from transportation and childcare).

54. *Id.*

55. *See* Harriet V. Coeling & Gloria Harman, *Learning to Ask About Domestic Violence*, 7 WOMEN'S HEALTH ISSUES 263, 263 (1997); *see also* Loraine J. Bacchus et al, *Evaluation of a Domestic Violence Intervention In the Maternity And Sexual Health Services of a UK Hospital*, 18 REPROD. HEALTH MATTERS 147, 148 (2010).

56. INST. OF MED., *supra* note 4, at 1.

57. *See A Brief History of Emergency Medical Services*, W. VA. DEP'T OF EDUC., http://wvde.state.wv.us/abe/Public%20Service%20Personnel/HistoryofEMS.html (last visited Jan. 30, 2015).

58. *Id.*

59. *Id.*

created to reduce the injuries and deaths on America's highways.[60] It was formed as a division of the Department of Transportation, and supports the Emergency Medical Service (EMS) system.[61] The predecessor to the NHTSA was the National Highway Safety Bureau, which focused on post-crash emergency care as one way to create safer highways. The creation of this agency launched the modern federal EMS system.[62]

The decision to place EMS responsibility with the NHTSA at the Department of Transportation, instead of within the Department of Health, Education, and Welfare[63] (now called the Department of Health and Human Services), was likely due to EMS's being considered then primarily a transportation rather than medical service.[64] The Department of Transportation's 1969 Highway Safety Program manual prioritized communications and transport over issues of medical equipment and personnel.[65] In fact, the only emergency discussed in that manual was first aid.[66] The scope of the system over time has grown to focus mainly on heart/cardiovascular diseases and traumatic injuries. These health issues have shaped EMS standards, even though "only a fraction" of EMS patients need assistance for such problems.[67]

The 1970s witnessed a rapid but ill-coordinated expansion of the EMS system across the United States. Substantial amounts of federal and private funding were allocated throughout the decade.[68] The goal was for each state to build an EMS system, with coordination occurring through regional programs; thus, states established EMS offices and designed a structure of EMS "regions" with funding from the EMS Systems Act.[69] Because of the emphasis on local control,

60. *The History of EMS at NHTSA,* HISTORY, NHTSA, http://www.ems.gov/history.htm (last visited May 22, 2015).

61. *See* 49 C.F.R. § 1.95(i)(19) (2015) (stating that federal regulations delegate the power to control emergency medical services (42 U.S.C. 300d-4) to the National Highway Traffic Safety Administration (NHTSA)).

62. *Id.*

63. *See* 42 U.S.C. § 300d (2012) (EMS is governed by Title 42 of the U.S. Code, which directs emergency management services.).

64. Manish N. Shah, *The Formation of the Emergency Medical Services System*, 96 AM. J. PUB. HEALTH 414, 416-17 (2006).

65. *Id.*

66. *Id.*

67. *Id.*

68. INST. OF MED., *supra* note 4, at 33-34.

69. *Id.* at 34.

most of the organization of systems was driven by local concerns and community characteristics.[70] This resulted in a "patchwork quilt" of systems criticized for conflicting educational standards and lack of coordination.[71] Developments the following decade compounded the balkanization of emergency medical services. In the 1980s, funding began to decline rapidly.[72] States were provided federal funding through block grants for preventative health services instead of targeted funded for EMS, and states began to use the funds for services other than EMS.[73] As funding decreased, many states chose to allow local city and county authorities to design models for EMS delivery; this phenomenon resulted in a "fragmented and diverse development" of systems, with rural EMS lagging behind its urban counterparts. [74]

By the 1990s, NHTSA recognized but did not fully rectify the deficiencies of the system. In 1996, EMS was isolated from other health services and only responded to acute illness and injury.[75] The agency therefore created a new strategic plan for the EMS system. The Agenda for the Future planned to integrate EMS into the health care system, which would act (instead of react) to promote community health.[76] By 2006, when the Committee on the Future of Emergency Care in the U.S. published its Emergency Medical Services: At the Crossroads,[77] it reported that EMS systems were often not well-integrated into health care, public heath, and public safety—though it operated at the intersection of all of these.[78] Recent criticisms of the current system include the charge that it is antiquated and needs to be transformed into one that is "innovative, patient-centered and highly integrated."[79]

70. *Id.*

71. *Id.*

72. *Id.* at 2.

73. *Id.* at 35.

74. *Id.*

75. *Id.* at 36.

76. *Id.* at 37.

77. NAT'L ASSOC. OF EMERGENCY MED. TECHNICIANS, ACHIEVING A 21ST CENTURY MEDICAL SERVICES SYSTEM: FIELD EMS MODERNIZATION AND INNOVATION ACT: REQUEST TO CONGRESS (2015), https://www.naemt.org/docs/default-source/advocacy-documents/emshd-documents/femsb-request.pdf?sfvrsn=2.

78. *Id.*

79. *The Field EMS Modernization and Innovation Act*, NAT'L ASS'N OF EMERGENCY MED. TECHNICIANS, http://www.naemt.org/advocacy/FieldEMSBill/FieldEMSBill.aspx (last visited May 23, 2015).

An alternative critique of the EMS system asserts that its focus is too narrow. Although those patients transported by ambulance to medical care tend to have more severe conditions than walk-in hospital patients, a significant percentage of those patients treated by EMS providers do not have life-threatening injuries. Many patients contact 911 because they have alarming symptoms or substantial pain and anxiety.[80] Recognizing that the overwhelming majority of EMS patients have relatively minor complaints, the IOM states that having EMS focus on the broader spectrum of complaints help it better meet the needs of patients who have less critical needs but nevertheless make up a significant portion of EMS calls.[81] The IOM emphasizes the need for skilled care in EMS to limit the adverse consequences of illness and injury.[82] A main goal of proposed Field Bill legislation is to bridge the gap in knowledge and skills in EMS and other health professionals.[83]

Despite these criticisms, the EMS System still plays a major part in the delivery of medical services. EMS responds to a huge number of emergencies; an estimated 240 million calls are made to 911 in the United States each year.[84] Forming the backbone of the prehospital system, EMS providers respond to calls that involve a medical or health emergency.[85] These personnel perform a variety of crucial functions, including response to the scene by ambulance or other emergency vehicle, triage, stabilization of life threatening injuries and/or medical treatment for the patient, and transportation to a medical facility (often called "definitive medical care").[86] In many urban and suburban areas, they are able to arrive on the scene within minutes to assess the patient, deliver medical care, and transport patients to facilities if the patient consents.[87] Many EMS personnel are trained in the use of sophisticated equipment, such as automated external defibrillators and electrocardiographs, along with life-saving medications, to provide patients a much broader array of services than were formerly available.[88] EMS professionals may be certified to

80. *Id.*

81. *See* INST. OF MED., supra note 4, at 22.

82. *Id.* at 19.

83. *Id.* For discussion of the Field Bill, see *infra* notes 100-106 and accompanying text.

84. *9-1-1 Statistics*, NAT'L EMERGENCY NO. ASS'N, https://www.nena.org/?page=911Statistics (last visited May 20, 2015).

85. *See* INST. OF MED., *supra* note 4, at 16.

86. *Id.* at 1-2.

87. *Id.* at 16.

88. *Id.*

use certain kinds of equipment and to administer certain kinds of medicine.

The structure and character of EMS agencies can vary considerably among communities. Agencies can be operated by local governments, private non-profit or for-profit companies, or fire departments. Providers can be volunteers or paid staff, depending on the community and its resources.[89] Paramedics have many vehicles in which to respond to medical incidents, ranging from an ambulance or a helicopter to a fixed-wing aircraft or a motorcycle.[90] Responsibility for the service is dispersed across agencies and organizations without integration and accountability at the local level.[91] Many fire stations across the U.S. are fire-rescue, [92] where the local EMS agency and the fire department operate as one entity, tasked with emergency services at the local level. Others operate separately, and according to the Institutes of Medicine, disputes over jurisdiction between EMS and fire personnel are "not uncommon."[93] Protocols, procedures, and equipment can differ among agencies in the same region—especially at the borders of states, counties, and cities[94]—because many systems are fractured "among smaller and smaller local lines."[95]

Responsibility for setting standards for EMS providers is scattered among a variety of entities. One of the main goals of NHTSA is to establish policy objectives for EMS programs.[96] In turn, state officials and administrators use these objectives in promulgating their EMS programs.[97] Moreover, an intricate network of organizations is involved in accreditation of training programs for EMS personnel. Such organizations include the Committee on Accreditation of

89. *Id.* (stating that many providers offer their services on a volunteer basis).

90. *See A Brief History*, *supra* note 57.

91. FED. EMERGENCY MGMT. AGENCY, NATIONAL RESPONSE FRAMEWORK 54 (2008), http://www.fema.gov/pdf/emergency/nrf/nrf-core.pdf ("Each participating agency maintains its own authority, responsibility, and accountability"); *see also* NAT'L ASSOC. OF EMERGENCY MED. TECHNICIANS, *supra* note 77.

92. *See* INST. OF MED., *supra* note 4, at 38.

93. *Id.* at 38.

94. *Id.* at 38-39.

95. *Id.* at 35.

96. *General Information: Overview*, NAT'L REGISTRY OF EMERGENCY MED. TECHNICIANS https://www.nremt.org/nremt/about/gen_info_overview.asp.

97. *See, e.g.*, NAT'L REGISTRY EMERGENCY MED. TECHNICIANS, EMS AGENDA FOR THE FUTURE (1996) [hereinafter EMS AGENDA FOR THE FUTURE], https://www.nremt.org/nremt/about/emsAgendaFuture.asp.

Educational Programs for the Emergency Medical Services Professions (CoAEMSP), the Commission on Accreditation of Allied Health Education Programs (CAAHEP), the National Association of EMS Educators (NAEMSE), the National Association of EMT's (NAEMT), the National Association of State EMS Officials (NASEMSO), and the National Registry of EMT's (NREMT).[98] Some states hold EMTs to specific agency requirements, such as the National Registry of EMT requirements and certification standards.[99] All states, however, have the final authority as to the educational and training requirements for EMS licensing and certification. [100]

While state EMS officials have called for standardizing the process of accreditation, [101] the most prominent efforts to forge coherence in the EMS system have centered in Congress. Several bills, known collectively as the Field EMS Quality, Innovation, and Cost-Effectiveness Improvement Act" have been proposed in Congress in recent years.[102] The goal of those bills is to create within the Department of Health and Human Services an Office of EMS and Trauma.[103] If passed, the bills would put the Department of HHS in charge of all aspects of EMS, including standardization of training, licensing, and credentialing.[104] The purpose of such a shift is to

98. NAT'L HIGHWAY TRAFFIC SAFETY ADMIN., EDUCATION AGENDA FOR THE FUTURE: A SYSTEMS APPROACH 1 (2000), http://www.ems.gov/education/EducationAgenda.pdf [hereinafter EMS EDUCATION AGENDA].

99. *About Emergency Medical Services (EMS),* NAT'L REGISTRY OF EMERGENCY MED. TECHNICIANS (2005), https://www.nremt.org/nremt/about/ems_learn.asp ("Currently 46 states require their EMS professionals to be certified by the National Registry of EMTS...").

100. EMS EDUCATION AGENDA, *supra* note 97, at 30.

101. COMM. ON ACCREDITATION EDUC. PROGRAMS FOR EMS PROFESSIONS, EMS ACCREDITATION FACT SHEET 2 (2010), http://www.coaemsp.org/Documents/Fact_Sheet_Accreditation_CoAEMSP.pdf. (The National Association of State EMS Officials issued a statement seeking a "single, nationally recognized accreditation agency").

102. *See generally* Field EMS Innovation Act, S. 2400, 113th Cong. (2014); Field EMS Quality, Innovation, and Cost Effectiveness Improvements Act of 2013, H.R. 809, 113th Cong. (2014).

103. *See* S. 2400 § 3 (2014) (The bills provide recognition of HHS as the "primary Federal agency with responsibility for programs and activities related to emergency medical services and trauma care.").

104. *See id.* at § 3 ("The Secretary shall address issues related to standardization of EMS practitioner licensing and credentialing. ... [This includes] promotion of the adoption by States of the education standards identified in the 'EMS Education Agenda for the Future: A Systems Approach.'").

provide for the highest quality of prehospital care and promote "comprehensive medical oversight of the education and training of field EMS practitioners."[105] The proposed legislation would also formally recognize field EMS providers as a health profession.[106] The National Association of EMTs has announced that it is committed to passage of the Field EMT bill.[107]

Although the Field Bill has not passed, other congressional actions reflect recognition of the current system's inadequacy. In 2014, Congress required the secretaries of Transportation, Health and Human Services, and Homeland Security to form a "Federal Interagency Committee on Emergency Medical Services" to coordinate agencies involved with EMS and 911 systems across the country.[108] Congress also established a National Emergency Medical Services Advisory Council to serve as an advisor for the Interagency Committee and the Secretary of Transportation.[109] Among its duties, the council is charged with providing recommendations about how to strengthen the EMS system through enhanced workforce development, education, training, and medical oversight.[110]

III. THE INADEQUATE EDUCATION OF EMS PERSONNEL ON DOMESTIC VIOLENCE

Screening for domestic violence by EMS personnel, then, is sorely needed but lacking under the existing system. Although there may always be barriers to screening for domestic violence in a prehospital setting—including lack of privacy and time limitations[111]—the current fragmentation and lack of accountability of the EMS system is a core part of the problem. In particular, the absence of universal continuing education or training on domestic violence for EMS staff renders the system ill-equipped for victims of this pervasive crime. Despite the

105. *Id.* at § 4.

106. *See* H.R. 809 § 4 (2014).

107. *See, e.g.,* NAEMT, *Field EMS Bill Introduced in Senate,* EMS1.COM (May 23, 2014), http://www.ems1.com/ems-advocacy/articles/1919082-Field-EMS-Bill-introduced-in-Senate/.

108. 42 U.S.C. § 300d-4(a)(1) (2012).

109. *Id.* at § 300d-4(b)(3).

110. NAT'L MED. SERVS. ADVISORY COUNCIL, CHARTER (2013), http://www.ems.gov/nemsac/may2013/NEMSACCharter20132015.pdf.

111. *See, e.g.,* World Health Org., *Reducing Violence Through Victim Identification, in* VIOLENCE PREVENTION: THE EVIDENCE 4 (2009), http://www.who.int/violence_injury_prevention/violence/4th_milestones_meeting/publications/en/ (discussing lack of privacy, training, and other barriers to medical professionals screening for domestic violence).

call for screening and counseling on domestic violence for all women to be implemented "throughout the health care delivery system,"[112] prehospital EMS medical technicians and paramedics who respond to emergency 911 calls have never received a nationwide call to participate in this crucial process. That gap is unlikely to be addressed while there is "virtually no accountability for the performance of EMS systems,"[113] and while EMS providers are not aligned with other health professionals.[114]

The widespread nature of domestic violence and the likelihood that EMS providers will encounter it on the job warrant ongoing emphasis on EMS training to recognize and assist victims. However, current national guidelines fall short of adequately addressing what could be lifesaving opportunities. The content of initial training of EMS providers is generally shaped by the NHTSA's Office of Emergency Medical Services and groups such as the National Association of EMS physicians.[115] The Office of Emergency Medical Services provides samples of what an EMS Education Agenda[116] should include. Although the terms "abuse" and "assault" are listed under the core content category in the agenda, no specificity is provided about what information EMS personnel need to know about abuse and assault.[117] In addition, the National Association of EMS Physicians has created the National EMS Core Content.[118] The Core Content acknowledges and describes the signs of abuse and neglect of a child, elder, or spouse as an emergent situation for EMS, emphasizing that the situation can be life-threatening if immediate

112. *See* Elizabeth Miller et al., *Integrating Intimate Partner Violence Assessment and Intervention into Healthcare in the United States: A Systems Approach*, 24 J. WOMEN'S HEALTH 92 (2015).

113. *See* INST. OF MED., *supra* note 4, at 4.

114. *Id.* at 40. (showing Venn diagram placing EMS in the center of three interlocking systems of public health, public safety, and heath care).

115. NAT'L HIGHWAY TRAFFIC SAFETY ADMIN., NATIONAL EMS CORE CONTENT 5 (July 2005), http://www.ems.gov/education/EMSCoreContent.pdf [hereinafter NATIONAL EMS CORE CONTENT].

116. *See* EMS EDUCATION AGENDA, *supra* note 97, at 35-37 (providing examples of what the National Core Content agenda should include in terms of education standards for EMS personnel).

117. *See id.* at 34.

118. NATIONAL EMS CORE CONTENT, *supra* note 115, at 3. This document is the first step in implementing the Education Agenda proposed in 2000 and states what knowledge and skills are necessary for EMS personnel regardless of their licensure level. *Id.* at 4. The document states that domestic violence is a core content topic and that all EMS personnel are expected to have knowledge of it. *Id.* at 24.

intervention does not take place.[119] However, the Core Content itself does not specify what the EMS personnel should know about domestic violence.[120]

Further, the National Highway Traffic Safety Administration and Health Resources and Services administration funded the creation of the National EMS Scope of Practice Model to improve the consistency of EMS personnel licensure levels among different states.[121] Although the Practice Model has no legal authority,[122] it provides the recommended minimum competency levels of knowledge and skills that EMS providers such as EMTs and paramedics should have. The Model does not include substantive information about domestic violence or abuse. However, the National Emergency Medical Services Education Standards, created by the National Association of EMS Educators,[123] states that all professionals of the Emergency Medical Services should have knowledge of abuse and neglect, including the health impacts these have on a patient.[124]

The Scope of Practice Model also goes on to elaborate on expectations for each of the four levels of EMS personnel: Emergency Medical Responders, Emergency Medical Technicians, Advanced Emergency Medical Technicians, and Paramedics.[125] The Emergency Medical Responder Instructional Guidelines[126] include medical/legal and ethics education standards which state that EMTs should understand reporting laws for several kinds of abuse, including

119. *Id.* at 24, 30.

120. *Id.* at 24.

121. NAT'L HIGHWAY TRAFFIC SAFETY ADMIN., NATIONAL EMS SCOPE OF PRACTICE MODEL 8-10 (2006), http://www.ems.gov/education/EMSScope.pdf. This model was used to develop and create the National EMS Education Standards. *Id.* at 9. This document asserts that states are supposed to use this model to frame their own scope of practice model for EMS legislation and regulation. *Id.* at 10.

122. *Id.* at 8.

123. NAT'L HIGHWAY TRAFFIC SAFETY ADMIN., NATIONAL EMERGENCY MEDICAL SERVICES EDUCATION STANDARDS 1 (2009), http://www.ems.gov/pdf/811077a.pdf (stating that EMS Educational programs must model their programs after these educational standards and content areas).

124. *Id.* at 48.

125. *See* NATIONAL EMS CORE CONTENT, *supra* note 115, at 6.

126. NAT'L HIGHWAY TRAFFIC SAFETY ADMIN., EMERGENCY MEDICAL SERVICES EDUCATIONAL STANDARDS 17 (2009), http://www.ems.gov/pdf/811077c.pdf (describing the necessary requirements that are expected of EMRs according to the educational standards, including mandatory reporting laws for several forms of abuse).

domestic abuse, elder abuse, and child abuse. The EMR guidelines provide additional information about child abuse and elder abuse, but do not provide further details on domestic violence.[127] More detail is available in the Emergency Medical Technician Instructional Guidelines,[128] which provide that EMTs should understand their own state laws about reporting. In addition, the Guidelines instruct EMTs that they are expected to take medical histories of their patients, including asking questions about sensitive topics such as physical abuse. The Guidelines for Advanced EMTs state that they are expected to make an assessment for suicide risk of patients in psychiatric emergencies, and to consider a history of trauma or abuse as a risk factor in this assessment.[129] Under the Guidelines, paramedics should have a complex comprehension of the healthcare implications of abuse and be able to assess the scene for signs of abuse and document any possible abuse situation.[130]

Thus, it is true that training for EMS personnel is likely to contain at least a degree of content on domestic violence; once EMS professionals are licensed or certified, however, any further information on domestic violence becomes solely optional for most of the United States. The national groups that shape EMS all envision that the nation's EMS personnel will receive continuing education throughout their careers,[131] but domestic violence is not emphasized in

127. *See id.* at 197.

128. *Id.* at 69 (stating what EMTs are required to know about abuse and assault according to the educational standards, including taking history on sensitive topics).

129. NAT'L HIGHWAY TRAFFIC SAFETY ADMIN., NATIONAL EMERGENCY MEDICAL SERVICES STANDARDS: ADVANCED EMERGENCY MEDICAL TECHNICIAN INSTRUCTIONAL GUIDELINES 66 (2009), http://www.ems.gov/pdf/811077d.pdf (stating that AEMTs should be able provide care for those in psychiatric emergencies and to accurately make an assessment for suicide risk).

130. NAT'L HIGHWAY TRAFFIC SAFETY ADMIN., NATIONAL EMERGENCY MEDICAL SERVICES STANDARDS: PARAMEDIC INSTRUCTIONAL GUIDELINES 361-62 (2009), http://www.ems.gov/pdf/811077e.pdf (stating what paramedics need to know about abuse and assault involving mandatory reporting requirements, how to take a patient's history on sensitive topics, and how to properly assess and document a scene for signs of abuse).

131. For the recertification process paramedics are expected to cover eight hours of obstetrics and pediatrics within their refresher course or continuing education. NAT'L REGISTRY OF EMERGENCY MED. TECHNICIANS, PARAMEDIC REFRESHER, REQUIREMENT, (2008), https://www.nremt.org/nremt/downloads/EMT.Paramedic.pdf. Out of the topics listed under Obstetrics and Pediatrics paramedics should be able to assess and provide care to an infant or child with suspected abuse or neglect. *Id.* However, because Obstetrics and Pediatrics are

that training. For example, the National Registry of Emergency Medical Technicians specifically highlights obstetrics and pediatrics for paramedics' continuing education.[132] However, no mention is made of domestic violence under either the mandatory or flexible content areas for continuing education credit.[133] The states, then, are left to specify what knowledge EMS should have on this topic.

Leaving states to determine whether EMS personnel must have training on domestic violence, however, has proved woefully insufficient. The vast majority of states have not mandated that EMTs have specific training in domestic violence. Only one state–Tennessee–currently provides explicit mandates for EMS personnel to have such training Tennessee law provides under the Emergency Medical Services Act that the state's Department of Health must approve and coordinate the use of materials concerning domestic violence as part of its training for EMS providers.[134] The curriculum, developed by the Department of Health and the Tennessee Coalition against Domestic Violence, is entitled: "EMS Response to Domestic Violence, A Curriculum and Resource Manual."[135] The only other state that has mandated domestic violence training in the past is Kentucky, whose statute formerly required all mental health professional, primary care physicians, nurses, and EMS personnel to take a three-hour course on domestic violence for continued and initial licensure or certification.[136] For emergency medical technicians, the statute required that training includes information on the dynamics and effects of domestic violence; legal remedies for victims; lethality and risk issues; model protocols for addressing domestic violence; available community resources and victim services; and reporting requirements.[137] However, the statute was subsequently repealed.

Some state laws tacitly acknowledge the value of training about domestic violence but fall short of Tennessee 's more comprehensive requirements. For example, Maine offers an optional continuing

---

under flexible core content and not mandatory core content, not all topics listed under obstetrics and pediatrics are required to be covered. *Id.* Therefore, it is up to the discretion of continuing education programs to provide material on the abuse and neglect of an infant or child, but it is not required.

132. *Id.*

133. *Id.*

134. TENN. CODE ANN. § 68-140-323 (2014).

135. TENN. CODE ANN. § 68-140-323 (2014); TENN. COMP. R. & REGS. 1200-12-01-.13 (2014).

136. KY. REV. STAT. ANN. § 194A.540 (West 2015).

137. KY. REV. STAT. § 311.6579 (West 2014) (repealed).

education course training on domestic violence for emergency medical services personnel, but without a licensure or continuing education requirement for such training.[138] While Texas provides guidelines for continuing training for EMS, domestic violence training is not required; rather, it is one of six optional "special considerations" topics that *may* be considered for training.[139] Florida requires domestic violence continuing education training for physicians, nurses, dental care providers, licensed clinical social workers, mental health professionals and "other health care providers,"[140] but such sweeping language does not specifically include EMTs and paramedics within the definition of medical providers. Other states, such as California,[141] Connecticut,[142] and Delaware,[143] are similar to Florida in requiring training in domestic violence for a range of medical personnel, but

138. Domestic Violence-Improving EMS Response, ME. DEP'T OF PUB. SAFETY (2015), http://www.maine.gov/ems/providers/training/domestic-violence.html.

139. *CE Hours, Content Areas*, TEX. DEP'T ST. HEALTH SERVS., https://www.dshs.state.tx.us/emstraumasystems/scehours.shtm (last updated Feb. 21, 2014). The CE hours must meet minimum content areas such as the "special consideration content" area. EMTs, for example, are required to have 6 hours in special considerations, and paramedics are required to have 12 hours in special considerations. *See id.* Under the special considerations content area, EMS personnel can receive continuing education by learning about abuse and assault. *Continuing Education Content Areas,* TEX. DEP'T ST. HEALTH SERVS., https://www.dshs.state.tx.us/emstraumasystems/ceareas.shtm.
However, abuse and assault is one topic out of six listed under the special considerations content area. *Id.* The other topics suggested are: neonatology, pediatrics, geriatrics, patients with special challenges, and "[a]cute interventions for the chronic care pt." *Id.* Thus, EMS workers can meet their minimum continuing education hours for the special considerations content area without ever having to learn about abuse and assault.

140. FLA. STAT. § 456.031 (2014).

141. CAL. BUS. & PROF. CODE § 2091.2 (WEST 2013) (California requires all applicants applying for medical licensure after September 1, 1994, prove that they have received instruction and coursework in "spousal or partner abuse detection and treatment.").

142. CONN. GEN. STAT. ANN. § 20-10b(b) (WEST 2013) (Connecticut requires all medical and surgical professionals seeking license renewal to complete at least one hour of training on domestic violence "during the first renewal period in which continuing education is required and not less than once every six years thereafter.").

143. DEL. CODE ANN. tit. 24, § 1723(c) (2011) (Delaware requires those who practice medicine to complete mandatory "training on the recognition of child sexual and physical abuse, exploitation, and domestic violence" each license renewal).

EMTs and paramedics are not included in the mandates.[144]

Even states that have convened groups or received federal grants to create EMT training on domestic violence have not mandated such training under statute or as a requirement of certification. For example, New Hampshire's Governor's Commission on Domestic and Sexual Violence received a grant from the U.S. Department of Justice in 1999 to create a domestic violence protocol for emergency medical services.[145] Yet, New Hampshire does not require that EMS providers have domestic violence training and the training has never been updated.[146] Similarly, the Alaska Department of Health and Social Services created a domestic violence resource, "EMS Response to Domestic Violence: A Curriculum and Resource Manual," in 1998.[147] The manual informs emergency health care providers that they are in a unique position to address domestic violence: "While focusing on medical needs, you need to use your powers of observation to be able to 'read between the lines' and be alert to the clues of domestic violence. Through this curriculum, you will develop the awareness necessary to recognize and confront this problem."[148] However, Alaska law does not mandate that EMS providers take the training or any training on domestic violence.

IV. A BLUEPRINT FOR REFORM

The failure of national accreditation standards and state laws to ensure adequate training on domestic violence for EMS personnel calls for fundamental changes in the current system. Perhaps the most important of these would be enactment of the Field Bill's proposed creation of an Office of EMS and Trauma within the Department of Health and Human Services.[149] Such an office could prescribe training that would help EMS providers better recognize symptoms of

144. *See id.*

145. N.H. GOVERNOR'S COMM'N ON DOMESTIC SEXUAL VIOLENCE, EMERGENCY MEDICAL SERVICES: DOMESTIC VIOLENCE PROTOCOL (1999), http://doj.nh.gov/criminal/victim-assistance/documents/emergency-medical-protocol.pdf.

146. *See* Email from Vicki Blanchard, BS, Paramedic Advanced Life Support Coordinator, N.H. Bureau of EMS, to Karen Oehme, Dir., Inst. for Family Violence Studies (May 11, 2015) (on file with authors).

147. *See generally* SECTION OF COMM. HEALTH & EMERGENCY MED. SERVS., ALASKA DIV. OF PUB. HEALTH, EMS RESPONSE TO DOMESTIC VIOLENCE, A CURRICULUM AND RESOURCE MANUAL 1 (1998), http://dhss.alaska.gov/dph/Emergency/Documents/ems/assets/Downloads/EMSDomesticViolence.pdf

148. *Id.* at 4.

149. *See supra* notes 101-06 and accompanying text.

domestic violation and assist victims. Still, the federal government should not be relied upon as the sole agent of change; states, medical professionals, and others can help integrate the EMS System into a broader effort to address this public health crisis.

In contrast with the Department of Transportation, which provides only limited support for related to domestic violence programs,[150] the Department of Health and Human Services has been concerned with the issues of domestic violence for decades. In 1995, HHS Secretary Donna Shalala spoke out on the need for greater medical engagement in combatting domestic violence:

> Domestic violence is a serious public health problem. As a result, we need doctors to do a lot more than treat injuries. We need our medical personnel to find out how the patient was injured. We need them to help prevent it from happening over and over. And we need medical workers to learn guidelines for treating abuse and learn where they can send victims for help.[151]

Commenting on grants to address the crime, HHS Secretary Tommy Thompson declared in 2003, "Domestic violence can be a downward spiral, but we must do all we can to stop this cycle to prevent pain, suffering and health problems in our communities."[152] Shortly thereafter, Thompson emphasized that prevention of domestic violence benefits families and communities:

> [V]iolence against women harms more than just its direct victim. It also harms the children, the abuser, the entire health of all of our families and communities. And for the health of our country, it's critical that we stop this cycle now. And that's one of your objectives: Stop the cycle now.

150. *See e.g.*, OFFICE OF SAFETY AND SECURITY, FEDERAL TRANSIT ADMINISTRATION, DISCRETIONARY GRANTS, *32 TRANSIT SECURITY NEWSLETTER*, 32 U.S. DEP'T OF TRANSP. 2 (2002), http://transit-safety.fta.dot.gov/Security/newsletters/pdf/vol32.pdf (noting that the Department provides funding for police to track domestic violence cases and awards grants to encourage domestic violence arrest policies such as improving tracking of cases).

151. Press Release, DOJ Office of Pub. Affairs, Attorney General Reno and Health and Human Services Secretary Shalala Meet with Advisory Council on Violence Against Women (July 13, 1995), http://www.justice.gov/archive/opa/pr/Pre_96/July95/388.txt.html.

152. Press Release, Ctr. for Disease Control and Prevention, CDC Funds Five Additional State Coalitions to Address Domestic Violence Prevention (Feb. 20, 2003), http://www.cdc.gov/media/pressrel/r030220b.htm.

> We just have to publicize it, get it out there, and do it.[153]

More recently, HHS Secretary Kathleen Sebelius recalled having spent years volunteering with victims of domestic violence and seeing "firsthand how vulnerable some women are in their own homes and their communities as a result of violence and abuse."[154] Regarding the Patient Protection and Affordable Care Act, which contains provisions for screening female patients for domestic violence, Sebelius said it is "more important than ever to support programs that help prevent violence and save lives."[155]

Moreover, commitment by the Department of Health and Human Services to preventing and responding to domestic violence extends far beyond calls for action by its leadership. The Department supports a wide range of programs that are intended to help victims of violence perpetrated by intimate partners. These include the National Domestic Violence Hotline,[156] the Teen Dating Violence website,[157] the Domestic Violence Service Finder Website Project,[158] and Prevent Connect, a national initiative to change how adolescent health, reproductive health.[159] In addition, HHS's Indian Health Service respond to sexual and domestic violence.[160] In the wake of passage of

153. Tommy G. Thompson, Sec'y of Health and Human Servs., Remarks at the Spring Meeting of the National Advisory Committee on Violence Against Women (Apr. 24, 2003), http://www.justice.gov/archive/ovw/docs/hhs_secremarks_sprngmeeting.htm.

154. Kathleen Sebelius, Sec'y of Health and Human Servs., *"Apps Against Abuse": Challenge to Help Address Sexual Assault and Dating Violence*, THE WHITE HOUSE BLOG (July 13, 2011), https://www.whitehouse.gov/blog/2011/07/13/apps-against-abuse-challenge-help-address-sexual-assault-and-dating-violence.

155. *Id.*

156. *About Us*, NAT'L DOMESTIC VIOLENCE HOTLINE, http://www.thehotline.org/about-us/ (last viewed May 20, 2015).

157. *Teen Violence*, CTRS. FOR DISEASE CONTROL, http://www.cdc.gov/violenceprevention/intimatepartnerviolence/teen_dating_violence.html.

158. *Domestic Violence*, U.S. DEP'T OF HEALTH & HUMAN SERVS., http://www.healthfinder.gov/FindServices/SearchContext.aspx?topic=253 (last visited May 20, 2015).

159. *Violence Against Women: Government in Action on Violence Against Women*, OFF. ON WOMEN'S HEALTH, U.S. DEP'T OF HEALTH & HUMAN SERVS. (Jan. 27, 2015), https://www.womenshealth.gov/violence-against-women/government-in-action/.

160. *See Domestic Violence Initiative*, INDIAN HEALTH SERVICE http://www.ihs.gov/dvpi/ (stating that IHS offers domestic violence, sexual assault, and sexual assault examiner community developed models).

the Affordable Care Act, the HHS also included screening and counseling for domestic violence in the "Women's Preventive Services Guidelines."[161] In contrast to this array of efforts by HHS to curb domestic violence, the Department of Transportation's involvement with these issues is much more limited in scope.[162]

Of course, institutional restructuring would be not an end in itself but rather a means of instituting effective EMS training on issues related to domestic violence. First, the complex dynamics of domestic violence and prevalence of the crime are essential components of training. EMS personnel should learn about state laws, particularly the scope of reporting requirements. Most states do not require first responders to report that they suspect domestic violence perpetration to law enforcement unless certain weapons--such as knives or guns—have been used by abusers. This is because victim advocates emphasize victim autonomy.[163] Competent adults, they believe—in contrast with children or the vulnerable elderly—need to be able to make decisions about their own lives.[164] Such autonomy should be explained in training so that EMS providers do not blame the victim for the injuries or judge victims who have not yet left the relationships. Trainers should describe the myriad reasons why victims may stay with abusive partners, including dynamics such as isolation from family and support systems, threats of further abuse and harm to victim and children, economic dependence, and ongoing danger and stalking even after separation.[165] Fortunately, every state and thousands of communities are home to victim advocate programs and domestic violence shelters that can partner with EMS agencies to help provide training.[166] Such programs provide essential community

161. *Women's Preventive Services Guidelines*, HEALTH RES. & SERVS. ADMIN., U.S. DEP'T OF HEALTH & HUMAN SERVS., http://www.hrsa.gov/womensguidelines (last visited Jan. 27, 2015); *see also* Patient Protection & Affordable Care Act § 2713(a)(3)-(4), 42 U.S.C. § 300gg-13(a)(3)-(4) (2011) (HRSA guidelines are incorporated into the ACA pursuant to section 2713).

162. *See Office of Safety & Security*, supra note 152.

163. Andrea J. Nichols, *No-drop Prosecution in Domestic Violence Cases: Survivor-defined and Social Change Approaches To Victim Advocacy*, 29 J. INTERPERSONAL VIOLENCE 2114, 2118-20 (2014).

164. *Id.*

165. *See* Silke Meyer, *Why Women Stay: A Theoretical Examination of Rational Choice and Moral Reasoning in the Context of Intimate Partner Violence*, 45 AUSTL. & N.Z. J. CRIMINOLOGY 186 (2012).

166. *See The National Prevention Toolkit on Domestic Violence for Medical Professionals*, INST. FOR FAM. VIOLENCE STUD., FLA. ST. UNIV., http://dvmedtraining.csw.fsu.edu/ (training focused on providing medical professionals about domestic violence); *Other Organizations,*

resources such as temporary housing, medical care, legal referrals, counseling, and a variety of other services to assist victims.[167]

Nor should regulatory requirements in this area be confined to pre-certification training on detecting and dealing with domestic violence. EMS should be able to screen patients, assess the scene for signs of domestic violence, and of course treat injuries in an appropriate manner; these skills require ongoing training. Thus, regardless of the amount of training any particular EMS professional receives before licensure or certification, ongoing "continuing education" training is essential. One important reason is that state laws governing domestic violence change over time. States have expanded definitions of domestic violence,[168] added protections for

---

NAT'L COALITION AGAINST DOMESTIC VIOLENCE, http://www.ncadv.org/need-support/resources (providing other national resources that provide support and furthers education regarding domestic violence); NAT'L DOMESTIC VIOLENCE HOTLINE, http://www.thehotline.org/resources/victims-and-survivors/#tab-id-1 (contains information regarding the domestic violence coalitions for each state which can link professionals to local domestic violence shelters and the services provided).

167. *Id.*

168. *See, e.g.*, N.Y. FAM. CT. LAW § 812 (McKinney 2013). The statute has been revised several times in the last decade: In 2008, Subsection 1, paragraph (c), substituted "regardless of whether they still reside in the same household" when defining members of the same family or household. *See* Orders of Protection "Members of the Same Family or Household", 2008 N.Y. Sess. Laws, ch. 326 (S. 8665) §7 (McKinney). Also in 2008, added Subsection 1, paragraph (e), including in the definition of members of the same family or household persons who are not related by consanguinity or affinity and who are or have been in an intimate relationship regardless of whether such persons have lived together at any time. The amendment also added factors the court may consider in determining whether a relationship is an "intimate relationship" including but not limited to: the nature or type of relationship, regardless of whether the relationship is sexual in nature; the frequency of interaction between the persons; and the duration of the relationship. Neither a casual acquaintance nor ordinary fraternization between two individuals in business or social contexts shall be deemed to constitute an "intimate relationship." *Id.* In 2009, amended Subsection 1's opening paragraph by inserting "sexual misconduct, forcible touching, sexual abuse in the third degree, sexual abuse in the second degree as set forth in subdivision one of section 130.60 of the penal law ," in the first sentence. *See* Attorneys for Children Receive Training or Education in Domestic Violence Prevention, 2009 N.Y. SESS. LAWS A. 9017 (McKinney). In 2013, amended the first sentence of the introductory paragraph by substituting "," for "or" following "assault in the third degree" and substituted "identity theft in the first degree, identity theft in the second degree, identity theft in the third degree, grand larceny in the fourth degree, grand larceny in the third degree or coercion in the

vulnerable children,[169] increased the categories of relationships that define when conduct is domestic violence,[170] and revised their codes in other ways that EMS staff would benefit from learning.[171] The nature of local services can also change; as communities grapple with the realities of domestic violence, they develop new resources to address the crime.[172] In addition, since new research better informs practice

---

second degree as set forth in subdivisions one, two and three of section 135.60 of the penal law " for "criminal obstruction of breathing or blood circulation or strangulation." *See* Courts-Jurisdictions-Crimes and Offenses, N.Y. Sess. Laws A.7400 § 1 (McKinney).

169. *See, e.g.*, ALA. CODE § 30-5-2 (which shall become effective 1/1/16). The changes significantly altered the 2010 amendments to the section. Among the changes: The following definitions will change materially: Abuse - definition changed to "An act of domestic violence committed against a victim, which is any of the following: (d) Child abuse definition changed to "Torture or willful abuse of a child, aggravated child abuse, or chemical endangerment of a child as provided in..." Creates a statutory category for a dating relationship. In (3), Dating Relationship defined as: a) A significant relationship of a romantic or intimate nature characterized by the expectation of affectionate or sexual involvement over a period of time and on a continuing basis during the course of the relationship. b) A dating relationship includes the period of engagement to be married. c) A dating relationship does not include a casual or business relationship or a relationship that ended more than 12 months prior to the filing of the petition for a protection order).

170. *See, e.g.*, COLO. REV. STAT. ANN. § 13-14-101 (West 2013) (expanding the definition of domestic violence to include a statement that a sexual relationship may be an indicator but is never a necessary condition for finding an intimate relationship). Additionally, the statute now defines "coercion" to include compelling a person by force, threat of force, or intimidation to engage in conduct from which the person has the right or privilege to abstain, or to abstain from conduct in which the person has a right or privilege to engage in. *Id.*

171. *See, e.g.*, Domestic Abuse Act, MINN. STAT. ANN. § 518B.01(6)(a)(14)-(15) (2015). Amendments in 2010added clauses providing the court with authority to order protection for and direct the care of pets or companion animals in domestic violence situations).

172. *See* Amy Saathoff & Elizabeth Stoffel, *Community-Based Domestic Violence Services*, 9 FUTURE OF CHILDREN 97, 98 (1999), https://www.princeton.edu/futureofchildren/publications/docs/09_03_6.pdf (noting that domestic violence services have expanded with more than 2,000 organizations increasing their range of programs available to victims, and that new services developing in communities include hotlines, shelter services, legal, health, vocational services, temporary housing, relocation services and safety planning). *See generally* Traci Lee, *First New Domestic Violence Shelter in a Decade Opens in Chicago*, MSNBC (Nov. 26, 2013), http://www.msnbc.com/martin-bashir/these-women-are-prisoners-plain-sight (new shelter is part of a collaboration of nonprofit groups and will provide a new range of

over time.[173] EMS personnel should be provided with up-to-date information. Moreover, because victim-blaming attitudes are distressingly pervasive[174] and remain persistent barriers to effectively providing aid for domestic violence victims,[175] professionals require repeated reminders that victims are not to blame. Given the role that emergency medical technicians and paramedics in treating victims of domestic violence, the attitudes of EMS personnel toward victims may significantly affect how the quality of services that victims receive. It seems obvious that beliefs that victims are somehow responsible for their own victimization[176] can seriously detract from their care.

Still another purpose of training and ongoing education is to foster effective communication between the EMS professional and the victim. The ability of medical providers to speak to patients in a private, nonjudgmental, and sensitive manner and the ability to make referrals to community resources, are essential elements of medical

services, such as housing assistance and counseling.); Tasha Tsiaperas, *Laws Aren't Enough to Stop Domestic Violence, Gov. Greg Abbott Says at Women's Shelter Opening*, DALLAS MORNING NEWS (Mar. 26, 2015), http://www.dallasnews.com/news/metro/20150326-laws-arent-enough-to-stop-domestic-violence-gov.-greg-abbott-says-at-womens-shelter-opening.ece (new shelter provides more long-term services up to 30 months to victims, which is a change from the standard 30-day shelter stay).

173. *See* Marianne Yoshioka & Deborah Choi, *Culture and Interpersonal Violence Research: Paradigm Shift to Create a Full Continuum of Domestic Violence Services*, 20 J. INTERPERSONAL VIOLENCE 513, 513, 551 (2005); *see also* Donald Dutton & Kenneth Corvo, *Transforming a Flawed Policy: A Call to Revive Psychology and Science in Domestic Violence Research and Practice*, 11 J. AGGRESSION & VIOLENT BEHAVIOR 457, 478 (2006); Lauren Cattaneo & Lisa Goodman, *What is Empowerment Anyway? A Model for Domestic Violence Practice, Research, and Evaluation*, 5 PSYCHOL. OF VIOLENCE 84, 87-90 (2015) (recommending a change in practice with domestic violence survivors, including consideration of cultural perceptions, a change from a formerly controlling system, and an empowerment process model to work with survivors).

174. *See* Ramani Garmella et al., *Physician Beliefs about Victims of Spouse Abuse and about the Physician Role*, 9 J. WOMEN'S HEALTH & GENDER-BASED MED. 405, 408 (2000).

175. *See* Enrique Gracia, *Intimate Partner Violence Against Women and Victim-Blaming Attitudes Among Europeans*, 92 BULL. WORLD HEALTH ORG. 380, 380-81 (2014), http://www.who.int/bulletin/volumes/92/5/13-131391.pdf.

176. *See* Christina Policastro & Brian K. Payne, *The Blameworthy Victim: Domestic Violence Myths and the Criminalization of Victimhood*, 22 J. AGGRESSION, MALTREATMENT & TRAUMA 329, 331 (2013).

care,[177] and thus, should be included in continuing education training. Yet, even when EMS providers recognize the physical consequences of domestic violence, they may not ask about the cause of a specific injury. Such reticence may occur if, for example, they are too embarrassed to raise the subject, or if they think that the victim somehow contributed to the violence.[178] Such a reaction may inhibit EMS personnel from offering essential referrals or information to victims, or from even seeking to identify victims in the first place.

Training is therefore also needed to ensure that EMS providers understand the effects of domestic violence on victims, and on victim and perpetrator behavior.[179] Perpetrators often minimize and deny their violence and can seem calm, reasonable, and polite to outsiders,[180] while victims can seem hysterical, unreasonable, confused, and uncooperative to those who provide services to them.[181] In

177. *See* Laura A. McCloskey et al., *Assessing Intimate Partner Violence in Health Care Settings Leads to Women's Receipt of Interventions and Improved Health*, 121 PUB. HEALTH REPS. 435, 435 (2006); *see also* Panagiota V. Caralis & Regina Musialowski, *Women's Experiences with Domestic Violence and Their Attitudes and Expectations Regarding Medical Care of Abuse Victims*, 90 S. MED. J. 1075, 1075 (1997) ("The majority of the respondents believe that doctors should routinely screen for abuse. As part of treatment, all women strongly recommended that doctors provide information on community and legal resources and assistance in seeking protective services.").

178. *See generally* Karin V. Rhodes et al., *"You're Not a Victim of Domestic Violence, Are You?" Provider-Patient Communications about Domestic Violence*, 147 ANNALS INTERNAL MED. 620, 622 (2007) (discussing the sometimes awkward conversations that physicians have when screening for domestic violence).

179. *See* Husni et al., *supra* note 53, at 237 (recommending new training curriculum for EMS personnel with topics such as increasing provider awareness and sensitivity, improving recognition of abuse, and increasing competency in safety planning); *see also Domestic Violence: The Role of EMS Personnel, supra* note 46 (stating the importance of EMS personnel's receiving continuing education of domestic violence to understand interactions at the scene, the potential harm, and the need for special communications that differ from other situations).

180. *See* Eric Gortner et al., *Psychological Aspects of Perpetrators of Domestic Violence and Their Relationships with the Victim*, 20 PSYCHIATRIC CLINICS OF N. AM. 337, 342 (1997) (stating that most men minimized the number, severity, and consequences of their violent episodes with their partners); *see also* Kristin Anderson & Debra Umberson, *Gendering Violence: Masculinity and Power in Men's Accounts of Domestic Violence*, 15 GEND. & SOC'Y 358, 359 (2001) (this document explores gendered depictions and interpretations of violent incidents; men often depicted their violence as rational, effective, and often minimized the severity of the violent encounters).

181. *See* Julie A. Domonkos, *The Evolution of the Justice System's Response to Domestic Violence in New York State, in* SUPREME COURT OF THE

addition, part of the training should be aimed at keeping EMS personnel safe when entering a home where domestic violence occurs. For example, EMS staff should know the red flags of a violent home and how to recognize and respond to threatening or menacing behavior. There have been documented cases of attacks on first responders who tried to intervene to protect victims.[182]

Another part of ongoing training should be familiarizing EMS providers with their responsibility for documentation. EMS personnel can observe the home environment and hear what the victim and those around her say.[183] They can also evaluate whether an explanation for the injury makes sense given the physical state of the scene. Documentation of the scene and of victim injuries can be important to pass along to the treating physician.[184] The skill and habit of documentation are also needed because EMS personnel can work in a variety of settings and be responsible for providing information to hospitals and clinics that use different protocols for passing along such information.[185]

CONCLUSION

The need to reform the Emergency Medical Services System is best understood in the context of the nation's broader attempt to stem the tide of domestic violence. Social service providers,[186] law

STATE OF NEW YORK, LAWYER'S MANUAL ON DOMESTIC VIOLENCE: REPRESENTING THE VICTIM (Jill L. Goodman & Dorchen A. Leidholdt eds., 5th ed. 2006), http://www.ncdsv.org/images/SCSNY_Lawyer's-Manual-on-DV_2006.pdf (stating that courts, law guardians, forensic evaluators, and police may mistakenly label domestic violence victims hysterical and uncooperative); *see also* Carole Warshaw, *Domestic Violence: Challenges to Medical Practice*, 2 J. WOMEN'S HEALTH 73, 74 (1993) (noting that medical professionals often label victims as the problem, calling them a "hysteric" or misdiagnosing them with mental health labels).

182. *See* D. Chappell & C. Mayhew, *Ambulance Officers: The Impact of Exposure to Occupational Violence on Mental and Physical Health*, 25 J. OCCUPATIONAL HEALTH AND SAFETY 37, 42 (2009).

183. *See* Husni et al., *supra* note 53, at 246 (stating that screening and documenting intimate partner violence from out-of-hospital providers may increase the opportunity to provide crucial resources to victims of domestic violence).

184. *See id.*

185. *See* Bruce Ambuel et al., *Healthcare Can Change from Within: Sustained Improvement in the Healthcare Response to Intimate Partner Violence*, 28 J. FAM. VIOLENCE 833, 835 (2013) (stating that different sites for clinical care hold different procedures for providing care to victims of domestic violence).

186. Bonnie E. Carlson, *Causes and Maintenance of Domestic Violence: An Ecological Analysis*, 58 SOC. SERV. REVIEW 569, 585 (1984) (stating that

enforcement,[187]the judicial system,[188] faith-based groups,[189] and many other entities[190] all have a major role to play in this vital enterprise. Providers of healthcare, in turn, are particularly charged with treating the devastating health consequences of domestic violence. While physicians and hospitals will no doubt always bear heavy responsibilities in the effort to identify and respond to domestic violence, EMS personnel routinely occupy the frontline of this undertaking. It is therefore crucial that they be well-trained in the best methods of identifying victims and meeting their immediate needs.

Thus, if the EMS System continues to virtually ignore domestic violence as a public health issue, instead focusing narrowly on

"the social service network needs to be analyzed in relation to domestic violence to identify gaps in services, and to improve and better coordinate existing services").

187. *See generally* Carla Stover, *Domestic Violence Research: What Have We Learned and Where Do We Go From Here?*, 20 J. INTERPERSONAL VIOLENCE 448, 451 (2005) (stating that law enforcement, with further coordinated community responses, can make significant changes for the domestic violence population, whereas one intervention alone has not yielded significant change. Coordination amongst disciplines is becoming more common considering research findings.).

188. *See* Deborah Epstein, *Effective Intervention in Domestic Violence Cases: Rethinking the Roles of Prosecutors, Judges, and the Court System*, 11 YALE J.L. & FEMINISM 3, 49 (1999) ("[T]he impact of impressive legislative innovations in the domestic violence field have been thwarted by a relatively stagnant justice system. To ensure that victims obtain the full relief to which they are now entitled, prosecutors, judges, and the court system must implement extensive reforms.").

189. Marie M. Fortune & Cindy G. Enger, *Violence Against Women and the Role of Religion*, NAT'L ONLINE RES. CTR. ON VIOLENCE AGAINST WOMEN (2005), http://vawnet.org/Assoc_Files_VAWnet/AR_VAWReligion.pdf (stating that religious leaders also can utilize their positions as community leaders to help shape the discussion of issues concerning violence against women).

190. *See* Carlson, *supra* note 188, at 585 ("The only way to meaningfully reduce the violence that pervades so many families is through fundamental changes in people's attitudes, and in the political and economic organization of our society."); *see also* Press Release, World Health Org., Violence Against Women: A 'Global Health Problem of Epidemic Proportions' (2013), http://www.who.int/mediacentre/news/releases/2013/violence_against_women_20130620/en/ (reporting that violence against women is global health problem that affects 30% of women worldwide and emphasizing the need for all sectors to engage in eliminating tolerance for violence against women).

technologically intensive interventions,[191] it will miss an important opportunity to improve public health. Sophisticated medical equipment and new, effective treatments for injuries remain important tools for EMS providers. A public health approach for preventing and addressing domestic violence, however, would include EMS screening for injuries and evaluating home environments, notifying physicians of possible causes of injuries and conditions, and educating patients on resources and prevention.[192] As congressional groups and other policymakers forge a modernized EMS system, enlisting EMS to battle the scourge of domestic violence should be part of the "vision for the 21st century for emergency services."[193]

191. Shah, *supra* note 64, at 421.

192. *Id.*

193. INST. OF MED., *supra* note 4, at 5.